

Professional self-regulation in a changing architecture of governance: comparing health policy in the UK and Germany

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This chapter compares transformations in professional self-regulation in the UK and Germany through the lens of governance. We introduce an expanded concept of governance that includes national configurations of state–profession relationships and places self-regulation in the context of other forms of governance. The analysis shows that a general trend towards network governance plays out differently. In the UK, a plural structure of network governance and stakeholder arrangements is emerging in the context of state-led change. In Germany, partnership governance between sickness funds and medical associations shape the transformations and act as a barrier towards the entry of new players.

Introduction

Across countries, transformations in the governance of the health professions are a significant aspect of new health policies. We can observe a general trend towards partnership and network-based governance together with marketisation and increased managerial control (Blank and Burau, 2007; Allsop and Jones, 2008). Existing systems of professional self-regulation have come under scrutiny, challenging the customary dominance of the medical profession in the healthcare division of labour and generating considerable scholarly debate (Allsop and Saks, 2002; McKinlay and Marceau, 2002; Salter, 2002; Gray and Harrison, 2004; DH, 2006; Hunter, 2006; Kuhlmann and Saks, 2008).

This article compares the transformations in professional self-regulation in the UK and Germany through the lens of governance. We introduce an expanded concept of governance to include national configurations of state–profession relationships and place self-regulation in the context of other forms of governance. Our aim is to move beyond the controversy over self-regulation as a barrier to the modernisation of healthcare and to highlight the complex factors that may block or facilitate change in professional governance. We argue that the concept of governance provides an opportunity for a more context-sensitive comparison between countries, so we can understand better how new health policies play out within the nation-based architecture of emergent governance practices. The UK and Germany have been chosen as case studies as they allow for the investigation of the dynamics of changing governance in the context of similarity and difference. The two countries are similar in terms of social, economic and demographic characteristics and the concepts of profession and regulation are broadly equivalent. Both countries have mature welfare state systems with non-market-based healthcare and a ‘public responsibility’ for ensuring that all citizens have access to healthcare. In both, there is a strong tradition of professional autonomy and medical dominance in healthcare politics.

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There are also major areas of difference, in particular in the methods of funding and the institutional frameworks for professional governance. The UK has a tax-funded National Health Service (NHS), the Beveridge model, while the German, or Bismarck, model is based on statutory health insurance (SHI) with healthcare jointly funded by compulsory contributions from employers and employees. While the reform strategies are similar, the emphasis differs and the form of healthcare politics creates barriers and facilitators to change that are specific to the two countries. In the European context, commentators have noted that the UK healthcare system has been in a period of rapid change, while the conservative-corporatist German system is a 'low motion' system (Freeman, 2000; Burau, 2005). These differences make for an interesting case study in which to explore transformations in professional self-regulation in the wider context of new governance practices.

We begin by discussing the concept of governance and the methodological issues that arise in comparing transformations in professional governance, and then move on to analyse the policy context by providing an overview of the regulatory structure and the main policy drivers for change in the two countries. We aim to compare changes in governance in three areas: the reconfiguration of top-down regulatory bodies; new models of governing through markets and managerial regimes; and shifts in the form of self-regulation. We conclude by highlighting how changing governance practices play out in the national configuration of state-profession relations.

Comparing changing professional governance in context: theory and method

In our analysis, we aim to link the study of professions to governance theory. A particular strength of the concept of governance is its flexibility and focus on the intersection of different forms of governance. Newman (2001) has introduced a typology of market, hierarchy and networks and highlighted the interplay of sets of governance practices. Following her analysis, she argues that:

State power is not dissolved – hierarchical forms of governance remain significant – but the idea of the state as a unitary actor is problematised, with more emphasis being placed on market mechanisms, network patterns of governance (governing through partnership and collaborative strategies), and the constitution of citizens as self-governing, responsible subjects. (Newman, 2005: 81)

Burau and Vrangbæk (2008), in a comparative study of five European health systems, also remark on the persistence of hierarchical forms of governance, but are able to demonstrate that the relative balance between forms of governance varies between countries. They show that the specific configuration of particular governance practices shapes the scope for action and agency of the medical profession.

Although these studies take different perspectives, and vary in their focus, both highlight the changing role of the state and the intersections between different governance practices. Clarke (2004: 25) argues for a more 'conjunctural' analysis in order to explore the 'unsettled formations' that can explain the connectedness between different levels of governance: 'This implies exploring how a specific

moment is shaped by multiple and potentially contradictory forces, pressures and tendencies' (Clarke, 2004: 25). This author highlights that changing welfare state policies are attempts to institutionalise new political-cultural formations and naturalise them as the 'best' way of doing welfare. These attempts:

bump into 'old' or residual meanings, commitments and institutions and are engaged by alternative emergent meanings.... These 'old' or 'residual' conceptions coexist – in a more or less conflicting way – with current dominant projects to reform nation, state and welfare. They form blockades or interruptions that the dominant strategies of reform and modernization have to overcome. (Clarke, 2004: 25, 29)

Within the health policy process, professional self-regulation is one key arena where such blockades and interruptions play out. At the same time, as Stacey (1992) has noted, the self-regulatory capacity of the medical profession may act as a 'buffer' against social conflict as an intermediary institution, thus indirectly serving the interests of government. Indeed, a number of scholars of the professions have pointed to the 'dualism' between self-interest and altruism in professional behaviour (Saks, 1999) and the position of the professions as both 'servants' and 'officers' of welfare states (Bertilsson, 1990). These notions direct our attention towards the state–profession relationship and the position of the medical profession within particular stakeholder arrangements in healthcare. The concept of governance, therefore, needs further investigation to include the regulatory power of professionalism and to see self-regulation as a particular form of governing health professionals and in consequence the organisation and delivery of services.

For our purpose, we expand the concept of governance to specify the role of the professions in the governance process. We draw, first, on Burau's (2005) model of 'actor-centred governance', which links professional action and agency to institutions; and, second, on Carmel and Papadopoulos's (2003) notion of 'operational policy', which is defined as the organisational arrangements and procedures for policy delivery and the particular 'mode of doing policy'. Carmel and Papadopoulos (2003: 32) argue that 'the analytical power of the concept of governance is that it allows enough flexibility to separately analyse both formal and operational policy while simultaneously highlighting their unity'. In healthcare the 'operational policy' and the 'modes of doing policy' are shaped by the self-governing capacity of the medical profession and the ways the state has delegated regulatory tasks to particular institutional actors. Thus, the configuration of the state–profession relationship is an arena in which to observe intersecting governance practices and 'unsettlements' in action.

The novel feature of our model is the integration of 'self-regulation' – the core of professionalism and medical power – into a changing architecture of governance in healthcare. The conceptualisation of self-regulation as an element of 'operational governance' helps to avoid a priori and often ideological assumptions about managerialism and professionalism as necessarily conflicting logics, and the 'either/or' questions on self-regulation and other forms of governing. For the purpose of our analysis, we introduce a distinction between three levels of 'operational governance':

- *institutional/hierarchical governance*: the regulatory bodies and stakeholder arrangements;
- *organisational governance*: models of governing through markets and managerialist strategies that impact at the meso-level of health organisations: either directly, or through measures that 'govern at a distance' (Miller and Rose, 1990) in the form of targets and performance measures;
- *self-regulatory arrangements* that reflect state–profession relations in a time-specific context.

Within the nation state, the 'unsettled formations' of state–medical profession relations, the latter with its self-regulatory powers, can be assessed empirically through cross-country comparison. A particular strength of this approach is to place the creation of 'new settlements' within existing configurations of assumptive meanings and interests. This allows account to be taken of 'context' and 'path dependency' in examining similar pressures in professional governance without assuming linear transformation. To provide an empirical basis for assessing transformations in professional governance across the two countries, the analysis draws on studies carried out by each of the authors,¹ documentary analysis and the work of other scholars.

Policy contexts and drivers for change

In terms of the governance of medicine, both state regulation and self-regulation have come under pressure to increase resources for health and raise quality across the Western world (Dubois et al, 2006). This has prompted strategies to reallocate resources and renegotiate roles. However, policy drivers themselves are shaped by the structure and politics of health systems and the politico-economic conditions that underpin welfare states. Given the significance of context, here we focus on the critical differences between Germany and the UK, although it should be noted that following devolution, health policies within the UK have diverged and the discussion below refers mainly to the NHS in England.

The structure of the health system: contrasting the models

In terms of macro-institutional structures, arrangements in the UK and Germany differ. In the tax-funded system in the UK the state has a key role in determining the quantum of resources allocated to healthcare through the Treasury, while the Department of Health sets policy for the NHS across the spectrum of care, free for all citizens at the point of access. The state has exercised control through the nationalisation of hospitals and a standardised system of primary care where patients are registered with a general practitioner who refers on, as necessary, to secondary care. Annual resource allocations are made through the Department of Health to local-level health authorities, now healthcare trusts, and through policy prescriptions for service development. The state also sets the level of supply for many health professionals, including doctors. Historically, compared to other European Union countries, the proportion of Gross Domestic Product (GDP) devoted to health annually and the ratio of doctors to population has been low (OECD, 2007). Within the NHS, which provides around 90% of healthcare, doctors are either employees

of health trusts or are in primary care working under contract. Until the 1990s, centralised policy making was combined with medical autonomy in clinical decision making and through self-governing institutions.

In Germany the state has established a legal framework for collecting and distributing funds for healthcare, but the responsibility for administration and decision making is delegated to a network of 'public law institutions' (Moran, 1999) with the Associations of SHI Physicians and SHI funds as the two pillars of 'joint self-administration'. This network structure characterises SHI care with statutory powers to regulate the organisation of healthcare and distribution of resources. The ratio of doctors to population and healthcare expenditure are high compared to other European Union countries, and staffing levels are almost twice those of the NHS (Maynard and Street, 2006; Blank and Burau, 2007). Roughly 50% of doctors are self-employed, office-based generalists and specialists, while most others are salaried employees in hospitals. Rationing and waiting lists were until recently an exception rather than a rule, and free choice of providers is culturally valued and a taken-for-granted right.

One consequence of this form of corporatism, itself a response to a fear of centralisation experienced under the Nazi regime, is the absence of uniform regulation of provider organisations. The various sectors and occupational groups are poorly coordinated. Ambulatory care, where corporatism is especially strong, is provided by office-based generalists and specialists and overseen by SHI institutions at both national and regional level; and hospital care is under the authority of the *Länder*. A second consequence of corporatism is that policy initiatives, including policies for Europe, have a limited impact. For instance, the recent European Working Time Directive does not affect the organisation of ambulatory care as doctors are mainly self-employed. In this article, we focus on ambulatory care as this forms the 'core' of corporatist regulation, and demonstrates the linkage between state and professional power (see Moran, 1999; European Observatory on Health Care Systems, 2000; Freeman, 2000; Dent, 2003).

There are important differences in the form of self-governance of the medical profession in the two countries although, in both, medicine has a monopoly of particular functions. In the UK, medicine became a self-governing profession prior to the welfare state, and the profession has regulated standards and performance through membership bodies. Under state licence, the General Medical Council (GMC) has the sole authority to register doctors and to remove from the register those whose performance has 'brought the profession into disrepute' through disciplinary procedures. Together with other specialist institutions, it oversees professional education and in recent decades has played a major role in setting standards. Within the NHS, doctors maintained dominance in clinical decision making and in local governance institutions. At the level of central policy making, doctors safeguarded terms and conditions of service through an elite corporatist politics, termed by Klein (1990) 'the politics of the double bed'. Until the 1980s, the implicit bargain was that doctors rationed access to remain within existing resources and that patients accepted long waiting times. This model is being replaced by centralised, hierarchical forms of regulation, with the use of more decentralised and flexible managerialist mechanisms operating within a quasi-market (Gray and

Harrison, 2004; Salter, 2007). Dent (2005: 632) has termed this latter strategy 'soft bureaucracy of enforced self-regulation'.

In Germany, the self-governing powers of the profession developed in parallel with the welfare state and compulsory social health insurance was introduced much earlier alongside a corporatist and decentralised system of regulation (Bäringhausen and Sauerborn, 2002). The arrangements were shaped by a corporatist welfare system that dates back to the Bismarckian era and, after the Second World War, by external political demands for federalism and decentralisation to mitigate centralised state power. This also shaped the position of medicine where professional power is exercised through both the self-governing professional bodies, the Physicians' Chambers, similar to the UK, and a range of SHI institutions, that have no UK parallel.

Physicians' Chambers are legally constituted bodies with mandatory membership for all doctors on the register (hospital and office-based doctors). They are responsible for controlling the standards of professional knowledge and practice through overseeing and accrediting specialist training and continuing education as well as updating medical ethics. The Associations of SHI Physicians include office-based generalists and specialists who provide ambulatory care under the SHI scheme; membership is mandatory. They have a monopoly in providing ambulatory care and are responsible for a range of economic issues, such as distributing resources among generalists and specialists, negotiating fees, and determining the ratio of office-based doctors to population across geographic areas. The Associations of SHI Physicians and the SHI funds are charged with cooperating to make decisions in the public interest. The SHI funds are expected to represent the interests of the users, thus counterbalancing the monopolist power of doctors. As a regulatory model, the joint self-administration of SHI care embodies ideas of partnership and network governance rather than hierarchical steering. It is based on the principle of balancing, and curbing different interests – including those of the state. In contrast, within the UK NHS, state power and control is accepted and embedded in the centralised structure, although critics have pointed to a democratic deficit and currently attempts are being made to increase local scrutiny (Hogg, 2007).

Policy drivers for change

Economic pressures have also played out differently in the two countries with consequent policy effects. In Germany, economic prosperity with rising incomes has allowed the rising costs of health insurance to be met. However, recently the economic situation has turned. Falling incomes caused by high levels of unemployment and demographic change impact directly on SHI funds. The sickness funds, health providers and users all struggle with increasing financial pressures and the significant cuts in SHI care. Consequently, cost containment has become the key policy goal, with the medical profession, and particularly the SHI doctors, the key target group for tighter economic controls (SVR, 2003, 2005, 2007). With a few exceptions, the self-governing bodies, such as the Chambers, are unaffected.

In contrast, since the inception of the NHS, UK governments have seen their primary role as containing costs and increasing efficiency. By the second Blair government, mounting public pressure to improve services, enhance patient safety

and increase patient choice, together with economic growth, led to increased resource allocation to health although with continuing pressure to raise quality (Maynard and Street, 2006). Furthermore, public trust in regulatory systems has been shaken by a series of well-publicised cases where doctors have caused serious harm to patients. The subsequent public inquiries have demonstrated failures in self-regulation and weak links between state and professional regulatory systems (summarised in DH, 2006). These have triggered a radical reform process and a restructuring of state–profession relations (DH, 2007).

In sum, while facing similar pressures, the peaks of economic prosperity, political factors and institutional structures have played out differently. The historical trajectories of the NHS in the UK and the Bismarckian model of welfare and healthcare in Germany created different configurations of state–profession relationships: in Germany, medical self-regulation is an integral part of welfare state governance, while in the UK, the institutions of self-governance are more separate from government. Furthermore, economic constraints and welfare state transformations shape the goals of new health policies in Germany, while in the UK the drivers for change are more complex, including economic interests as well as democratic renewal. The next section examines how the different drivers play out and shape the creation of ‘new settlements’ within state–profession relationships.

Changing modes of governance and strategies for controlling medical work

Governments of both countries have aimed to contain costs while at the same time raising the quality of care, adopting a so-called ‘third way’ approach (Giddens, 1998; Newman and Kuhlmann, 2007). Both have introduced a form of internal market and a number of managerial procedures to change the behaviour of the major players in healthcare. In consequence, existing systems for healthcare delivery are subject to continuing organisational change and are moving towards ‘hybrid’ forms of governance and healthcare finance (Lewis et al, 2006; Blank and Burau, 2007). These ‘hybrids’ shall be unpacked and explored in greater detail in the following sections, using the three levels of ‘operational governance’ as a framework for comparison.

Transformations of regulatory bodies

In Germany, the 2004 Health Reform Act extended the key regulatory body of SHI care, now the Federal Commission (*Gemeinsamer Bundesausschuss*) (see Table 1). The intention is to link the different regulatory systems of ambulatory and hospital care and include representatives of user groups. Although SHI care is no longer solely governed by a ‘monolith’ of sickness funds and physicians’ associations, the expansion of stakeholders and the introduction of new players is limited and service coordination underdeveloped (SVR, 2005). In contrast, a number of new arm’s-length regulatory bodies have been established in the UK, which attempt to ensure that doctors and managers follow practices leading to more cost-effective care (see Table 1). The National Institute for Health and Clinical Excellence (NICE) (covering England and Wales), responsible for appraising and producing guidance on the cost-effectiveness of new and existing technologies, in particular, has gained international

significance as a pioneer in assessing treatment regimes and disseminating evidence-based practice (Concentin et al, 2006). It also recommends clinical guidelines for practice and assesses audit methods. It has developed and supported methods to obtain evidence from patients of their experiences and consults with user representatives (Davies et al, 2006). NICE does not itself make decisions about which treatments should be funded but makes recommendations to the Department of Health, which in turn issues guidance that may be mandatory.

Table 1: Transformations of regulatory bodies in the UK and Germany

Transformations	UK	Germany
Regulatory bodies	Nine councils governing the health professions (UK); Council for Healthcare Regulatory Excellence (UK)	Restructuring of the Federal Committee, inclusion of user representatives and the German Hospital Society; new bodies in the context of disease management programmes; inclusion of user representatives; a number of new expert groups
New agencies of public control	NICE (England and Wales); National Patient Safety Agency (England, Wales and NI); Healthcare Commission (England)	Institute of Quality and Efficiency in Healthcare; main goal is to improve evidence-based patient information
Stakeholder arrangements	Inclusion of the service users and new forms of more active involvement in the policy process; more lay members on professional councils, associations and regulatory bodies; a range of regulatory bodies of various professional groups; new bodies that coordinate activities	Inclusion of the service user alongside the principle of delegation of user interests to the SHI funds; exclusion of the health occupations from the regulatory bodies; no statutory recognition as a profession; lack of coordination of services

In Germany, efforts to improve standardisation and control of healthcare decisions have not been developed institutionally to the same extent. In 2004, an ‘Institute of Quality and Efficiency in Healthcare’ was established as part of the SHI system. Headed by a physician, its main task is to provide safe, evidence-based information for patients. This maintains medical control and is less transparent and publicly accountable than, for example, NICE and it does not involve consumer groups. In effect in Germany, delegation of responsibility for policy making and financial distributions to the SHI system releases the state from the burden of costs and thus explains the lack of state activity in this sphere.

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Differences in the stakeholder arrangements are especially strong when it comes to the entire health workforce. In Germany, health occupations apart from the medical and dental profession are excluded from decision-making arenas and are denied the statutory rights of a profession – except psychotherapists who are now included in the Associations of SHI Physicians and apply a position in the middle range (European Observatory on Health Care Systems, 2000). This is in sharp contrast to the developments in the UK where currently nine regulatory bodies cover an expanding range of health professions (Allsop and Jones, 2006, 2008). Statutory recognition and a comprehensive jurisdiction provide the opportunity for a range of health professions to act as independent players, counterbalancing the medical view and medical interests.

New forms of organisational governance: marketisation and performance management

Marketisation and managerialist strategies have become the cornerstones of new governance. In the UK, in the early 1990s an internal market was introduced in the NHS. The aim was to split the functions of purchasing and providing and introduce service pricing. Purchasers now commission services for populations, and prioritise services within a given budget; providers compete for contracts on the basis of cost and quality. Most recently, in order to increase the extent of provider cooperation and the coordination of services across health and social care, mergers between commissioning agencies, the primary care trusts, are taking place at the meso-level (Sheaff et al, 2004). A more pluralist supply system using the private sector has been encouraged, with the objective of increasing competition and widening choice for patients (DH, 2004). Private finance has been sought for NHS facilities and foundation trusts, hospitals within the NHS with greater financial freedom to raise funds, have been established (Allsop and Baggott, 2004).

In Germany, a series of reform acts demonstrates a commitment to innovation in the health system, which, unlike the NHS, already had a purchaser–provider split. Similar to the UK, policy incentives are shaped by competition and marketisation and focus on financial incentives (Glaeske et al, 2001). However, while the NHS is currently expanding its funding base and services, the coverage of SHI care is increasingly limited through the exclusion of several services. This is coupled with an erosion of the principle of solidarity in SHI funding. Co-payments by patients have been introduced and the users of healthcare services are burdened increasingly with additional out-of-pocket expenses. The 2000 Health Reform Act launched pilot projects on different ways of contracting and introducing structural change, but studies suggest that the projects have largely failed to contain costs and improve quality (Tophoven, 2003). Following this experience, more complex strategies were developed with incentives for organisational change, such as new forms of flexible contracting and pilot projects to introduce office-based generalists as gatekeepers (*Hausarztmodelle*). However, participation is voluntary for both providers and users (Kuhlmann, 2006).

Another cornerstone of the new governance practices is the focus on standard setting and guidelines to govern professional performance with varying forms of sanction for non-compliance held by different players. In the UK, one method has been for state-sponsored agencies to draw on different forms of expertise (for

example, clinicians and service users) to make recommendations for policy. NICE is an example already mentioned (Davies et al, 2006). Another example is the policy guidance for the treatment of particular illnesses or client groups contained in the National Service Frameworks (NSFs). These have been drawn up by working parties composed of various interests reflecting a more plural approach to policy making. This contrasts with the medically dominated, secretive and elitist bargaining of the past. The process allows the state to gain legitimacy, yet maintain a veto and play off interests while also controlling implementation at the meso-level. This is achieved through setting performance targets for managers and carrying out audit and inspection through arm's-length bodies such as the Healthcare Commission, which benchmarks standards and publicises outcomes.

In Germany, disease management programmes (DMPs) for chronic illnesses are the clearest sign of intervention in the SHI system (Pfaff et al, 2003). First introduced in 2002, DMPs are shaped by the politics of cost containment and financial incentives for both the SHI funds and doctors. They are coupled with the Risk Equation Scheme for SHI funds, and evaluations focus on the financial effects only. Although the programmes attempt to improve quality of care through the standardisation of treatment, they do not establish a coherent system of target setting, monitoring and evaluation with benchmarks, and do not encourage providers to use quality measures to compete for patients (Kuhlmann, 2006). These strategies remain underdeveloped (SVR, 2000/01), and there are few sanctions against those who provide a poor quality of care (Sauerland, 2001). Although data collected by the medical profession and the SHI funds are now more extensive, for instance hospitals produce reports on the quality of care, there is opposition to benchmarking standards. Both parties express concern about the validity of data and the opportunities for misuse, arguments also made by the medical elites in the UK, but overridden by government. In Germany, the alliance between doctors and sickness funds, and the absence of powerful external players allow interest-based strategies to prevail.

A further example of state-led supply-side changes in the UK NHS are policies geared to changing the distribution of tasks between health professionals and introducing a greater 'skill-mix' in care. Policies for new forms of human resource management and professional development are aspects of 'operational governance' at the interface of organisations and professions. For instance, some nurses and pharmacists have enhanced roles in diagnosing and prescribing for a specific range of conditions. A large and diverse workforce of health support workers has developed (Saks and Allsop, 2007) and there is a drive to integrate care through multiprofessional teamwork both in the community and in hospital settings. Integrated care models and greater cross-service coordination are also policy goals in Germany, but the effect has been limited (SVR, 2005, 2007) with only 1% of the SHI budget allocated for integrated care (Greß et al, 2006). In Germany, integration refers to cooperation between office-based generalists and specialists, and between ambulatory and hospital care, rather than doctors working with other health professions. This is in sharp contrast to the UK where interprofessional working, particularly across the health and social care divide, is a priority.

In summary, a major factor in explaining these different policy priorities is the relative powers of policy actors within the health system. In Germany, the governance of medical performance is mainly exercised within the SHI system and outcomes

depend on negotiations between doctors and sickness funds; policy incentives focus on initiatives by the medical profession and on financial controls. By contrast, within the NHS there are centralised initiatives for workforce planning and measures to encourage the integration of health and social care as well as the financial incentives to substitute less well-paid staff for more highly-paid professionals. There are also more complex institutions and procedures for defining and monitoring standards and weighing the 'evidence' for treatment interventions.

Transformations in professional self-regulation

In both the UK and Germany, changes in the forms of professional governance challenge traditional relationships between key policy players, although in different ways. In the UK at the macro-level, the institutionalised corporatism of the old NHS has been replaced by policies that are state led and follow government priorities. Elite doctors are drawn into the policy process but more often as experts contributing their knowledge (as in NSFs), and less often as negotiators to support narrow professional interests (Allsop and Baggott, 2004).

At the meso-level of management within the NHS, government-driven managerial imperatives take precedence over claims based on the knowledge and expertise of doctors through various forms of clinical governance. Financial and other constraints have led to a loss of medical autonomy in treating patients in the hospital in the manner, time and place of the doctor's choosing. The other side of the coin is that there are limits to the regulatory reach of the new measures. Some studies have indicated resistance (Hunter, 2006; McDonald et al, 2006; Salter, 2007; Waring, 2007) as well as 'gaming' to reach the targets set by government in response to what Germov (2005) calls 'hyper-rationality'. The loss of autonomy may be balanced by financial gains as NHS doctors are more highly paid than doctors in other European countries. General practitioners who manage their practices well, have made financial gains from new contracts as have hospital doctors, who can also combine NHS work with private practice (Maynard and Street, 2006). In Germany, by contrast, office-based doctors struggle with the ongoing cuts in SHI care and the 2006 strikes by hospital doctors are proof of an increasing dissatisfaction (Janus et al, 2007).

In the UK, following the Shipman Inquiry (2004) into serial killer, general practitioner, Harold Shipman, the proposed reforms to the institutions of professional self-governance mark a new phase in state-profession relations. One consequence has been closer cooperation between state agencies and the professional bodies to identify and deal with poorly performing doctors, for example through the National Patient Safety Agency. Currently in the implementation phase, but accepted by medical elites, are proposals that will transform the architecture of professional governance to achieve greater public accountability. There is to be an appointed rather than an elected GMC with a lay majority; an independent tribunal to adjudicate on disciplinary cases; and an introduction of systems to assess physicians' continuing fitness to practise. There will be regular relicensing of all doctors based on employer appraisal, and the periodic recertification of specialists led by the Royal Colleges but undertaken locally (DH, 2006, 2007). In response, professional governance networks have strengthened; leadership roles for specialty institutions are more clearly articulated; and there is ongoing public debate on a 'new professionalism'

that redefines professional knowledge, standards and engagement with patients in the contemporary context (Royal College of Physicians, 2005; GMC, 2007).

In Germany, there are currently no signs of such radical state interventions, but bottom-up changes and redefinitions of professionalism can be observed that include performance management, clinical guidelines and networking. An emerging, locally based network culture may support more cooperative working styles and the medical profession has developed its own strategies to enhance the quality of care. In recent years, community-based, loosely linked working groups and 'quality circles of physicians' have sprung up rapidly. After an initial phase of scepticism, the medical profession has embraced the language of evidence-based medicine and quality management (Hasenbein et al, 2005). Continuing education has become mandatory and is controlled by the profession. Credit points, for instance, can be earned by participation in quality circles (Kuhlmann, 2006).

Although professionalism is being redefined in both the UK and Germany, there are crucial differences in the agency exercised by the medical and other health professions. In the UK, change has been state led, while in Germany, the configuration of SHI regulation with the two pillars of sickness funds and physicians' associations provides the space to bypass public control and to form both strategic and opportunistic alliances. The debate on a mechanism for benchmarking care highlights how the interests of different players converge to create a barrier to change and transparency. This was especially evident in the process of negotiating the DMPs: both the SHI funds and physicians had an interest in avoiding competition and therefore blocked the attempts to establish a comprehensive benchmarking system (Kuhlmann, 2006; Burau and Vrangbæk, 2008). The corporatist arrangement can also act as a barrier to the inclusion of new services and provider groups. For example, in 2004 the integration of acupuncture into SHI care was the subject of negotiations within the Federal Committee but reimbursement from the funds for this work was rejected. In the event, doctors increasingly offer acupuncture but patients must pay for the service themselves. If SHI funds were to cover the service, it would be contrary to the medical interest as fees would be fixed and the service more regulated. Equally, it is in the interest of government and SHI funds to contain costs by blocking new services even if there is a demand from patients (Kuhlmann, 2006).

In summary, barriers to governing medical performance are embedded in policy frameworks and are not simply an outcome of the self-regulatory powers of doctors. In Germany, the medical profession and SHI funds may form temporary alliances to avoid transparency, and the politics of cost containment may meet with medical interests to exclude new players and services. In the UK by contrast, change has been state led, pressures for greater accountability, transparency and democratic renewal are stronger and the professionalisation and statutory recognition of a range of health professions more advanced.

What matters in the changing architecture of health professional governance?

This article has set out to compare transformations in professional self-regulation in healthcare through the lens of governance theory. The UK and Germany have

provided a case study of how similar policy drivers and strategies play out in the differing architecture of governance and customary practices in state–profession relations. We have suggested expanding the concept of governance in ways that, first, include self-regulation as one element of ‘operational governance’ in healthcare existing alongside new organisational governance practices, and, second, link institutional arrangements to actors and agency.

Placing professional self-regulation in the wider architecture of changing governance practices brings into focus the significance of nation-specific configurations of state–profession relationships. In both the UK and Germany, new regulatory bodies and new forms of managing medical performance have been established that challenge customary interpretations of professional self-regulation, leading to a reassessment of what constitutes professionalism in the contemporary context. Nevertheless, national regulatory frameworks and interest-based politics are shaping how accommodations are reached. In Germany, the state has delegated power and responsibility for the organisation and delivery of healthcare. The self-regulatory capacity of medicine is integrated institutionally as a cornerstone of the self-administered SHI system. This network-based regulatory framework creates a paradoxical situation. Despite a shift in the overall balance of power towards the sickness funds and a more interventionist state, in practice this has provided a number of opportunities to reaffirm medical dominance in the policy process. The corporatist rearrangement tends to act as a barrier to both greater public control and the entry of new players, such as other health professionals who may challenge medical power.

In the UK, the state has policy oversight of the organisation of care; the supply system is more integrated both in terms of the primary–secondary care divide and between health and social care. Hierarchical state-led governance over health policy has strengthened in the NHS in ways that have fractured customary forms of state–profession bargaining and the state has engaged a broader range of players in steering policy goals. Although state–profession relationships are more strongly controlled by an interventionist state, stakeholder arrangements are increasingly plural. These developments have combined to produce a radical expansion of network-based and meso-level governance practices. The various arenas of governance create a possibility for ‘new settlements’ (Clarke, 2004). Medical dominance thus struggles to assert itself on a number of ‘different fronts’. How these developments play out in future will depend on how various stakeholders exercise their powers.

In sum, our analysis suggests that transformations in medical self-regulation strongly intersect with other forms of governance, sometimes with effects that are unintended or contradictory. An understanding of the changing ‘architecture’ of different governance practices requires an assessment of multiple levels of governance and how they intersect, and how they allow for new ‘formations’ in the health policy process. To this end, the concept of governance provides opportunities for a more context-sensitive comparison of *how* new health policies play out in different national contexts.

Note

¹ Data were drawn from: a study on the modernisation of healthcare in Germany using document analysis, a survey of office-based physicians and interviews and focus

groups with a range of health professionals (Kuhlmann, 2006); UK studies on NHS modernisation processes based on document analysis (Allsop and Baggott, 2004); and medical regulation in an international context based on document analysis and expert interviews (Allsop and Jones, 2006, 2008).

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